Council on Medical Practice

April 10, 2026
2 – 4 p.m.
Location: Kalahari I
Zoom connection information:
Meeting ID: 847 5532 1931
Passcode: 488344
LINK: https://us02web.zoom.us/j/84755321931?pwd=xlPxuBTJcOhLISyTM2FyRapD6A4S1T.1

AGENDA

1. Call to order by Triwanna Fisher-Wikoff, MD, chair (David Vaughan, MD, vice chair)
2. Introductions
3. Approval of report – November 13, 2025
4. Current business
   a. Consider California AFP's draft resolution, "Measures that Matter"
   b. Discuss recent downcoding practices by payers
   c. Discuss postpartum coverage in Texas Medicaid
   d. Discuss new CME reporting requirements involving CE Broker
   e. Practice pain points
      i. Referral difficulties
      ii. Medicare Advantage in today's market
      iii. "Skinny" health plans
      iv. Other problems
   f. AI tools in FPM
5. Other business
6. Adjourn

Jonathan Nelson and Heather Osborne are the staff liaisons for this council.

COUNCIL ON MEDICAL PRACTICE REPORT

Author: Jonathan Nelson
Meeting date: November 13, 2025
Meeting Location: Renaissance Dallas Addison Hotel, Addison, Texas

---

The following members attended the meeting in person: Triwanna Fisher-Wikoff, David Vaughan, Nimat Alam, Vicky Bakhos Webb, Oscar Garza, Elizabeth Hill, Nicole Lopez, Donald Niño

The following members attended the meeting virtually: Jennifer Greenblatt

The following members attended the meeting as guests: Emily Briggs, Jessica Garcia, Troy Fiesinger, Richard Young, Puja Sehgal, Christine Liu, Dwane Broussard, Josh Splinter, Mahvash Husain

This council is staffed by Heather Osborne and Jonathan Nelson.

ACTION ITEM

1. That the TAFP communications team develop an online toolkit of team-based care resources.

MINUTES

1. The meeting was called to order by Triwanna Fisher-Wikoff, MD, chair at 2:32 p.m.
2. The council report from the meeting on April. 4, 2025, was approved.
3. Tom Banning gave the council a presentation on the results of the 89th Texas Legislature and led a discussion of health care ramifications of H.R. 1, or the One Big Beautiful Bill Act passed by Congress.
4. The council discussed recent downcoding tactics implemented by health plans and AAFP's advocacy efforts to address the issue.
5. The council discussed advocacy efforts to address problems related to patient attribution. The council reviewed a presentation scheduled to be delivered to the Member Assembly later in the 2025 TAFP Annual Session and Primary Care Summit.
6. The council reviewed team-based care resources to be used in a toolkit for tafp.org.
7. The council discussed recent developments in the use of AI in primary care clinics.
8. The meeting was adjourned at 5 p.m.

Resolution: Measure What Matters for Value-based Payment

Whereas: Barbara Starfield showed 30 years ago that first contact, continuity, comprehensiveness and coordination (the 4Cs) lead to better health, increased longevity and decreased total cost of care.

Whereas: Barbara Starfield's findings have repeatedly been demonstrated for the last 30 years in this country and other countries.

Whereas: We now have the ability to measure 2 of the 4Cs: Continuity and Comprehensiveness; and with some work could add first contact.

Whereas : ABFM's Center for Professionalism and Value in Health Care recommends measuring "Measures that Matter"(1) – specifically: Trust, Continuity, Comprehensiveness and Person-Centered Primary Care Measure (PCPCM).

Whereas: More FM physicians are opening DPC practices and patients are selecting them despite out of pocket costs, since both want to ensure that the trusting physician-patient relationship is the priority and these practices are one way to the 4 Cs.

Whereas: the goal of Pay for Performance Measures and HEDIS measures were to improve quality and decrease cost in medicine, but we have not seen either. And the high administrative burden of how measures have been done, has seen some diverting of funds from frontline care to data inputting and analysis.

Whereas: Hedis measures can tell you if a population needs more or different care, however Hedis measures cannot tell you if an individual physician or practice is doing an excellent job. 4 C Primary Care is very complex, and individual lab and preventive markers do not reflect if care is excellent. (2)

Whereas: Spot check HEDIS measures can help identify population or zip code areas that may need a modified model of care and/or resources.

Whereas: Current HEDIS measures can incentivize "cherry picking" "healthier" communities. HEDIS penalizes physicians who care for individuals with more need and/or complex disease.

Whereas: Target goals are patient-centered and resonate with patients and medical teams. Target goals (versus percentiles) removes barriers to medical practices sharing successful operational changes that align for better outcomes.

Whereas : The goal of measurements was to show excellent care of more individual patients without increased administrative burden. However, measuring **percentile goals versus target goals**, means only a small % of PC practices can be considered very good,

even if all are within a few percentiles of each other and are providing excellent care. This disincentivizes participation, especially of small practices that may not be able to afford the infrastructure staff to track measures, and discourages sharing of best practice system improvements between practices. In addition, percentiles are a mathematical goal that does not resonate with patients and health care teams.

Whereas: Given how healthcare is reimbursed, there are actual financial disincentives to continuity and comprehensive and coordinated care in many practice settings.

Whereas: AAFP's September 2024 Position Paper: "Value-based Payment Models for Primary Care" introduction says: " (AAFP) believes value-based Payment (VBP) should support collaborative partnerships between patients and physicians, improve the quality and patient outcomes of care and reduce unnecessary health care spending. To achieve these aims, VBP for primary care must support the four key functions of primary care (i.e., first contact access, comprehensiveness, coordination and continuity), which are essential to meeting the goals of improved quality and reduced spending" (3) However AAFP language on VBP measurements is varied through AAFP policies.

Whereas: Milbank Memorial Fund articles and PC scorecards show the chronic disinvestment in PC and shortage of PC.(4)

Whereas: given the increasing national access shortage of PC physicians, that patient access not be diverted to administrative cost burdens (in time and $) that have not proven improved quintuple aim.

RESOLVED: CAFP supports shifts in quality value measures in

primary care settings to "measures that matter" that moves towards the

Quintuple Aim.

RESOLVED: Update CAFP's "Pay for Performance" policy, transitioning to measures

that support the core 4Cs (first contact access, comprehensiveness, coordination and

continuity) with less administrative burden as supported by AAFP's introduction of

September 2024 Position Paper on Value-based Payment Models for Primary Care(2);

and measures monitoring total cost of care % investment in PC while concurrently

monitoring number of PC physicians who provide 4C PC (given the national access

shortage).

RESOLVED: CAFP supports policies for measuring quality or value, where business goals should be targets, not percentiles.

RESOLVED: CAFP recommends that AAFP support national bodies, including CMS and NCQA, to shifting quality and value measures to "measures that matter" and targets (versus percentiles).

(1) Measures that Matter | The Center for Professionalism and Value in Health Care

(2) The Challenges of Measuring, Improving, and Reporting Quality in Primary Care | Annals of Family Medicine

(3) www.aafp.org/about/policies/all/value-basedpayment.html

(4) The Health of US Primary Care: 2025 Scorecard Report — The Cost of Neglect | Milbank Memorial Fund

AAFP urges feds to investigate downcoding as threat to primary care

https://www.aafp.org/news/government-medicine/investigate-downcoding.html

Dec. 10, 2025, News Staff — The AAFP is taking action on a growing threat to physician compensation and the viability of small and independent family medicine practices: insurers' growing use of downcoding to reduce payment.

"Payer-initiated downcoding programs are not new, but they are spreading, and it's time to get a handle on it" said Stephanie Quinn, the Academy's senior vice president for external affairs and practice experience.

The Academy's Nov. 21 letter urged the Department of Justice, the Federal Trade Commission and CMS to investigate with the aim of ensuring transparency, accountability and fair competition.

"Instead of denying a claim outright, which is obvious and can be appealed, insurers have begun simply paying for primary care and other services at a lower rate," Quinn said. "They're making these determinations using algorithms that are applied to the limited information submitted on a claim form, without meaningful input from doctors."

While the AAFP supports accurate and fair billing, Quinn said the lack of transparency about downcoding programs raises questions about whether they are uniformly applied for all physicians. Following years of vertical integration, downcoding could create unfair advantages for payer-owned sites of care.

"Beyond the risks downcoding poses to fairness and competition in a health care marketplace already suffering from the effects of consolidation, we're concerned about the losses and administrative burdens sure to be felt by small and independent practices," Quinn said.

What is downcoding and how does it affect family physicians?

Downcoding occurs when a health insurer

1. applies unilateral, likely algorithm-generated criteria, to
2. assign an evaluation and management or other code that's lower than what the physician has billed,
3. without consulting the physician about the claim.

The outcome is reduced compensation, which physicians often discover only after receiving the lower payment. From there, their options are to accept the lower payment or appeal, which can take time and other resources away from patient care.

"Primary care practices have been significantly affected and may be disproportionately harmed by these programs," the AAFP said in its letter. "A primary care visit often involves complex decision-making for numerous interrelated issues, from preventive care to management of chronic conditions to coordination of additional services with other providers and specialists.

"This is an existential threat to many practices—especially those in rural and underserved areas who may be the only health care access point for entire communities."

An August white paper published by the health care consultancy KZA puts that threat in stark terms: "Revenue erosion can result in six-figure annual losses for practices."

AAFP advocacy on downcoding

The Academy in recent months has been in touch with AHIP (formerly America's Health Insurance Plans) as well as specific payers, including Blue Cross Blue Shield Association, to express concern about downcoding and to ask for clarification about the process.

The Academy told policymakers in the Nov. 21 letter, "To date, the AAFP and its members have not been able to secure any guidelines, standards or rules from payers with which physicians could educate themselves to improve their billing and documentation in order to avoid having their claims downcoded.

Downcoding resources

- *FPM* Getting Paid blog: Cigna's downcoding policy gets pushback from physician groups
- FAQ: Answers to common questions about coding for evaluation and management services
- Template letter: Write to individual payers

"These programs appear to be using algorithms that lack transparency and are applied without full clinical context," the letter added. "If these programs are designed to ensure accurate billing and prevent fraud, waste and abuse, then these policies should be transparent, fair and uniformly applied."

"If left unchecked, this tactic could further entrench vertical integration and lead to unfair practices," Quinn said. "The lack of transparency around downcoding so far makes it harder to ensure claims integrity and identify potential market manipulation."

Academy calls on regulators to act on downcoding

The AAFP's letter urged the federal agencies to

- investigate the use and impact of downcoding algorithms;
- require disclosure of downcoding criteria and ensure uniform application, including to health plan-owned practices;
- mandate streamlined, transparent appeals processes with clear standards and timelines; and
- engage physicians and regulators in oversight of these practices.

"This letter is just our opening move," Quinn said. "We believe that primary care physicians' unique and important role in health care should ultimately exempt them from downcoding as it's being used right now. The financial and administrative burdens are too great, and the threat to patient outcomes is too high."

Physicians are already speaking out against downcoding

In an NBC News story on how downcoding hurts physicians, Academy member Terry Wagner, DO, FAAFP, said, "Some computer program is deciding what my level of care is. If they question my level of care, then ask for my notes. Look at the tests I ordered. Look at my charts."

Ryan Nadelson, MD, internal medicine department chair at Northside Hospital Diagnostic Clinic in Gainesville, Florida, wrote in a *Stat* editorial: "By tying reimbursement to diagnosis codes instead of the actual clinical work performed, this policy devalues physicians' time and judgment. It assumes that complexity exists only in 'rare' or 'severe' codes, when in truth, outpatient medicine is full of nuance that cannot be captured by a single label. The result is a distorted view of patient care that punishes doctors for doing their jobs thoroughly—and ultimately undermines the quality of care patients receive."

What AAFP members can do

Academy members can register their concerns by customizing the AAFP's member-exclusive template letter about downcoding and sending it individual insurers.

"We plan to keep members informed about this issue, including how they can get involved in fixing it," Quinn said.

The AAFP Advocates Against Payer Downcoding Policies and For Improved Primary Care Payment

A key priority for the American Academy of Family Physicians (AAFP) is to improve primary care payment while reducing the administrative burdens associated with getting paid. To advance these goals, the AAFP advocates across multiple channels, including actively monitoring and responding to public and private payer policies, especially those that negatively impact primary care practices. In addition to addressing specific payer actions, the AAFP engages in broader advocacy efforts through ongoing dialogue with national stakeholders, participating in coalitions focused on payment reform, and developing tools and resources to support chapters and members in their local efforts.

In recent years, several major commerical payers have implemented policies that automatically lower the E/M code, resulting in lower payments based solely on the diagnosis on the claim submission. Most recently, Cigna Healthcare announced its new Evaluation and Management (E/M) Coding and Accuracy (R49) policy (https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R49_Evaluation_and_Management_Coding_Accuracy.pdf) (effective October 1, 2025), which will permit automatic downcoding of E/M claims without reviewing the supporting clinical documentation.[1] The policy states, "Cigna may adjust the E/M CPT® code 99204-99205, 99214-99215, 99244-99245 to a single level lower when the encounter criteria on the claim does not support the higher level E/M CPT® code reported." Note: Just prior to the publication of this article, Cigna paused their downcoding policy in the state of California (www.cmadocs.org/newsroom/news/view/ArticleId/50993/Cigna-agrees-to-pause-controversial-downcoding-policy).

The AAFP strongly opposes downcoding policies, arguing that this approach ignores CPT guidance which allows office/outpatient E/M coding based on either medical decision-making (MDM) or total time spent on the date of service—factors that cannot be determined from diagnosis codes alone.

WHY IT MATTERS FOR FAMILY PHYSICIANS

Family physicians regularly manage multiple chronic conditions, coordinate care with specialists, address behavioral health and account for social drivers of health—all within the span of a single patient visit. Diagnosis codes do not capture these complexities and cannot be fairly judged by algorithms or claims encounter criteria.

The AAFP warns that automatic downcoding risks:

- Undervaluing the complexity of family medicine
- Increasing administrative burden through appeals
- Straining small and independent practices financially, particularly in rural and underserved areas
- Eroding trust by implying that physicians who code higher-level visits are engaging in fraudulent behavior
- Encouraging inappropriate undercoding, which fails to capture the complexity of care accurately

AAFP RECOMMENDATIONS TO PAYERS

The Academy is urging all payers, but especially those who have established downcoding policies and procedures, to:

- **Pay claims as submitted** unless a clear, documented rationale exists to do otherwise.
- **Clearly and proactively communicate** the program's parameters. Notify physicians when they are identified

CPT GUIDANCE

- E/M CPT code set and reporting guidelines clearly indicate that documentation from the medical record is needed to determine if the level of MDM or total time spent on the date of the encounter has been correctly coded.[2] This cannot be determined by the primary diagnosis on the claim alone.
- CPT guidance states, "The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."[3]

Authors: Hannah Luetke-Stahlman, MPH; Brennan Cantrell; Karen Johnson, PhD

Journal editors were not involved in the development of this content.

as outliers, including a description of the data used and the reasons why, before adjusting individual claims. Offer these physicians additional education.

- **Streamline appeals and determination processes** with an easy-to-use appeals process, making determinations in a timely manner and providing detailed information on the remittance advice if an appeal is denied.
- **Identify a pathway** for being removed from the program. Equip physicians with a clear understanding of the changes or improvements necessary to no longer be considered an outlier and thus removed from the program.
- **Disclose** the use of artificial intelligence (AI), algorithms and analytic solutions. In accordance with the AAFP's Ethical Application of Artificial Intelligence in Family Medicine policy (www.aafp.org/about/policies/all/ethical-ai.html), we urge payers to transparently communicate their methods for executing this program to their in-network physicians and practice managers to offer assurances that determinations are being appropriately made.

The AAFP has also raised (www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/cigna-downcoding-em.html) these concerns directly with Cigna and the insurer advocacy group AHIP (formerly America's Health Insurance Plans), urging them to promote consistency and transparency in downcoding policies across their member plans.[4] In a formal letter, the AAFP called on AHIP to encourage proactive communication with physicians, streamline appeals processes and disclose the use of AI in payment determinations. The AAFP emphasized that automatic downcoding undermines the complexity of care provided by family physicians. This presumption is likely to lead to inappropriate undercoding, which fails to accurately capture the complexity of care and the resources required to meet patients' needs.

PROTECTING PRIMARY CARE'S VALUES

The AAFP emphasizes that inappropriate downcoding policies could disproportionately harm family physicians, whose practices rely heavily on E/M services. With the United States facing rising rates of chronic disease, the AAFP argues that strong primary care is foundational and critical for both improving patient outcomes and reducing health care costs.

As part of our ongoing advocacy efforts, the AAFP has offered to collaborate with AHIP, Cigna and other payers on educational outreach rather than use punitive payment cuts. Additionally, the AAFP recently conducted our annual Payer Engagement and Alignment Survey (www.aafp.org/pubs/fpm/issues/2023/1100/beyond-the-beltway.pdf) to assess the degree to which payer behavior aligns with AAFP policies and positions across the following five key domains[5]:

- Reducing administrative burden
- Limiting performance measurement
- Increasing primary care investment and encouraging value-based care progress
- Supporting advanced primary care and population health capabilities
- Protecting physicians' autonomy and scope of practice

Results of the survey inform our ongoing payer engagement strategy and advocacy priorities. The Academy remains committed to ensuring that family physicians are resourced and compensated fairly to provide high-quality, comprehensive care in every community.

STATE CHAPTER ADVOCACY

For those who would like to directly engage with payers in their markets on the issue of downcoding, the AAFP has equipped state chapters with a customizable template letter to support your advocacy against downcoding policies of state and regional health plans. Visit our E/M coding webpage (www.aafp.org/family-physicians/practice-and-career/getting-paid/coding/evaluation-management.html) to access a customizable template letter for opposing downcoding by health plans. You'll also find answers to common coding questions there as well.

REFERENCES

1. Cigna Healthcare. Evaluation and management coding and accuracy. Accessed September 24, 2025. https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R49_Evaluation_and_Management_Coding_Accuracy.pdf
2. American Medical Association (AMA). Payer evaluation and management (E/M) downcoding programs. What you need to know. Accessed September 24, 2025. www.ama-assn.org/system/files/payer-em-downcoding-resource.pdf
3. AMA. CPT® evaluation and management (E/M). Office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99417) code and guideline changes. Accessed September 24, 2025. www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
4. Cantrell B. Cigna's downcoding policy gets pushback from physician groups. Getting Paid. A blog from FPM journal. September 16, 2025. Accessed September 24, 2025. www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/cigna-downcoding-em.html
5. Cantrell B, Freeman K. AAFP's health plan advocacy and engagement. *Fam Pract Manag*. 2023;30(6):4-5.

New CME requirement rules go into effect Sept. 1

Physicians must use CE Broker to report CME to TMB for licensure

By Jonathan Nelson | April 02, 2026

https://www.tafp.org/news/new-cme-requirement-rules-go-into-effect-sept-1

A handful of laws passed in the 89th Texas Legislature mean some important changes are in store for physicians needing to achieve and report CME requirements to renew their licenses. As of September 1, 2026, Texas physicians needing to renew their licenses must log their CME through CE Broker, a commercial online platform for tracking and reporting continuing education.

The new requirement stems from passage of **Senate Bill 912** in the 2025 legislative session by Sen. César Blanco, (D-El Paso), making Texas one of a growing number of states mandating the use of **CE Broker** as the exclusive system for tracking and verifying continuing education for a variety of licensed professions.

The company offers a free “Basic” account that it says is sufficient to report required CME for licensure, but it offers three tiers of paid membership ranging from $39.99 to $199.99 per year that provide enhanced support and management features. TMB suggests physicians sign up for an account before September 1 to become acquainted with the system.

The basic CME requirements for licensure remain unchanged. Physicians must report a total of 48 hours every two years, with 24 of those being formal Category 1 or 1-A hours — *AMA PRA Category 1 Credits,™* AOA Category 1-A credits, and AAFP Prescribed credits all suffice — and 24 informal hours in any format.

While the imposition of CE Broker into the TMB licensing and renewal process will likely increase family physicians’ administrative burden, TAFP members will enjoy an advantage, according to TAFP COO Kathy McCarthy. All CME credits members earn from TAFP and AAFP will be automatically logged in their CE Broker accounts. “If you are a member of the Academy or you are maintaining board certification, you are earning more than twice the CME needed for your state license,” she says. “So it may make sense to count all of your AAFP and TAFP CME first and then fill in the rest of the required 48 credits in the simplest way you can. Your Academy invests significant resources to track and report your CME as a

way to reduce your stress and administrative burden. Hopefully, those efforts will help as the medical board transitions to this new system."

For more information on CE Broker and a tutorial on creating an account, **watch this video.**

Other CME news to note

In addition to the courses mandated by the Texas Medical Board on pain management, ethics/professional responsibility, and human trafficking, family physicians must now complete a course on pregnancy-related medical emergencies. With the passage of the Life of the Mother Act, or **S.B. 31,** by Sen. Bryan Hughes, (R- Mineola), family physicians along with doctors in 11 other specified specialties must take a single one-hour course on pregnancy-related medical emergencies. TMB offers the only eligible course for free on **MyTMB.** All family physicians are required to complete the course, regardless of whether they provide obstetrical care.

The pain management requirement has been reduced from two hours every renewal period to two hours for the first two renewal periods, then two hours every eight years after that.

The human trafficking requirement will now be required only once. If TMB approves more than the one course it currently offers, direct patient care physicians will need to take a course every six years.

TAFP now provides AOA Category 1A credit!

This year, TAFP applied for and received accreditation through the American College of Osteopathic Family Physicians to provide AOA Category 1-A credit for our CME courses. TAFP's director of CME and compliance, Jessica Miley, is excited to offer AOA credit for the first time at this year's **Texas Family Medicine Symposium,** June 5-7 at the Signia by Hilton La Cantera Resort and Spa in San Antonio.

"We chose to offer osteopathic CME credit to better support our DO members in meeting AOA requirements and accessing relevant educational opportunities," she says. "This ensures our programming remains inclusive, meets the needs of osteopathic physicians, and continues to provide strong value to their membership with TAFP."

CME

KARIM HANNA, MD

Assembling Your AI Toolkit in Family Medicine

© CHAD HAGEN

This curated list of AI tools that save time and support evidence-based decisions offers a solid starting point for building your own AI toolkit.

Artificial intelligence (AI) has swiftly shifted from futuristic hype to everyday reality. Family physicians are uniquely positioned to benefit from this shift because our work requires managing broad medical knowledge as well as time-consuming administrative tasks, all while nurturing the doctor-patient relationship. AI isn't here to sideline us; it's here to support us, like a reliable assistant who handles some of the work, freeing us to focus on the human elements that drew us into this field.[1]

This article describes what family physicians should consider when assembling their AI toolkit. I've curated this list through hands-on use in busy clinics and teaching rounds, and I've tested these tools in real-world scenarios, prioritizing those that are free or low-cost, user-friendly, and adaptable. Of course, the AI landscape evolves faster than influenza strains in winter. New tools pop up weekly, and what

ABOUT THE AUTHOR
Dr. Hanna is associate professor and program director at the University of South Florida Family Medicine Residency Program, Tampa. He is also a clinical informaticist and author of the AI+MedEd blog, https://karimhannamd.substack.com. Author disclosure: Dr. Hanna discloses that he serves in an advisory role with ReachRx, an AI platform focused on pharmaceutical information.

Downloaded from www.aafp.org/fpm. Copyright © 2025 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the website. All other rights reserved. Contact copyrights@aafp.org for questions and permission requests.

works today might be outdated tomorrow. This list of AI tools isn't exhaustive, but it's a solid starting point for family physicians looking to dip their toes in the AI waters without drowning in options.

To make this toolkit actionable, I've organized it around five key categories and use cases:

1. Clinical knowledge assistants, which excel at rapid, evidence-based information retrieval — such as pulling up the latest clinical guidelines mid-visit,

2. Decision support tools, which go further, aiding in diagnostic reasoning, differentials, and management plans by synthesizing patient data into structured insights,

3. Documentation support, which can save you time,

4. Administrative support, which can save you frustration,

5. Learning support, which can help you stay current amid information overload.

This list of AI tools isn't exhaustive, but it's a solid starting point for family physicians.

The key message to remember across all categories is that while AI augments our expertise, the buck still stops with us. Always verify outputs, especially for clinical or high-stakes decisions.

1. CLINICAL KNOWLEDGE ASSISTANTS

Case: A 45-year-old patient with type 2 diabetes asks about the newest glucagon-like peptide-1 (GLP-1) agonist options during a routine follow-up visit, and you need to quickly access up-to-date, citable evidence without derailing the visit.

In moments like this, when a new medication is the subject of TV commercials before CME courses or when memory recall fails or guidelines shift, clinical knowledge assistants act as your on-demand librarian. These tools are experts at fetching reliable information from trusted sources in seconds. OpenEvidence stands out here, purpose-built for clinicians by querying PubMed, Food and Drug Administration labels, and peer-reviewed literature (including the *New England Journal of Medicine*, *JAMA* Network, and most recently *American Family Physician* and *FPM*) to deliver concise, evidence-based summaries with citations.[2] It's free with professional verification, awards American Medical Association PRA Category 1 CME credits per query, and is HIPAA-compliant for organizations that enter into a business associate agreement with the company. In the case above, querying OpenEvidence for "current GLP-1 agonists for type 2 diabetes, including cost and efficacy comparisons" would yield a synthesized response with links to trials such as Semaglutide Treatment Effect in People with Obesity (STEP) and Semaglutide Unabated Sustainability in Treatment of Type 2 Diabetes (SUSTAIN). This not only informs the patient conversation but models evidence-based practice for learners, which is important in residency practice settings. I've used OpenEvidence on rounds to confirm heart failure therapies, turning potential "I'll look it up later" conversations into teachable moments on the spot.

A tool that pairs nicely with OpenEvidence is Perplexity, which offers a broader, real-time search and answer engine, ideal for nonclinical scenarios such as state-specific prescribing rules or emerging trends. It's not limited to medical resources, so double-check sources, but it's handy for gray areas overlapping with things outside of medicine — say, integrating wearable data into diabetes management.

Tip: Start with OpenEvidence for pure clinical queries to avoid web noise. It is easy to use. Then layer in other tools for

KEY POINTS

- AI tools can enhance family physicians' efficiency by supporting clinical decisions, reducing administrative burdens, and improving documentation.
- This curated AI toolkit includes clinical knowledge assistants, decision support tools, documentation support, administrative support, and learning support, all designed to save time and improve patient care.
- While AI tools are valuable, physicians must always verify AI-generated outputs to ensure accuracy and maintain the human touch in patient care.

contextual breadth. Together, they can save precious minutes during visits, letting you pivot back to the patient with confidence.

2. DECISION SUPPORT TOOLS

Case: A 32-year-old woman presents with persistent fatigue, intermittent rash, and joint pain, and you're building a differential diagnosis without immediate specialist input.

Decision support tools go beyond information retrieval and offer active reasoning, helping craft differentials and plans while encouraging thoroughness. Glass Health AI is a gem in this area. You can input symptoms, history, and labs, and it generates a structured differential with rationales, often flagging overlooked rarities. In the above case, it might highlight autoimmune conditions such as lupus or Sjögren's, prompting targeted tests. I love using it in residency clinics to spark discussions (e.g., "Why prioritize this over that?") and to foster critical thinking without spoon-feeding answers. It's subscription-based but offers trials, and its transparency builds trust.

Doximity GPT (which recently acquired Pathway) takes a guideline-centric approach, answering queries like "Algorithm for incidental pulmonary nodule in a smoker?" with step-by-step summaries and CME credits. It's HIPAA-compliant and free for verified users, making it seamless for quick consultations. For instance, I've queried it on nuanced lipid management following advanced panels, ensuring my care plans align with American Heart Association/American College of Cardiology (AHA/ACC) consensus.

Other tools such as VisualDx shine for visual diagnostics. For example, you can upload a photo of a patient's rash, and the tool compares the image against a vast library, which is great for dermatology-heavy family medicine practice. You could use any large language model (LLM) AI program to do this, but most of them would first ask you a series of tailored questions that help with diagnosing a lesion or rash. Another tool, Isabel, now integrated with DynaMed, lists differentials from symptoms, adding depth for complex cases as well.

Tip: Use these tools early in ambiguous cases to broaden your net, but edit queries and outputs to fit the patient's unique story. When used properly, decision support tools can help reduce the cognitive load, allowing us to focus more on the "why" behind decisions.

3. DOCUMENTATION SUPPORT

Case: After a hectic day of back-to-back visits, you're staring at a pile of unfinished charts, dreading "pajama time" at home.

Documentation burden leading to physician burnout is real. It's the thief that steals our evenings. AI scribes tackle this by ambiently transcribing visits and drafting notes, letting you stay present with patients. AI scribe options abound, including Doximity Scribe (currently free for verified clinicians), Nabla Copilot, DAX, and Heidi.ai. Some vendors offer freemium models (i.e., basic services are free, but advanced features require a fee), while others charge hefty prices per user or per encounter, so do your homework on pricing. You'll also want to choose a product that can integrate with your EHR, if possible, for seamless workflows. I foresee a continued race to better pricing with time, until companies can roll out advanced features like auto-pended orders integrated with your EHR.

To start using an AI scribe,[3] make sure the tool is approved by your organization

Decision support tools go beyond information retrieval and offer active reasoning, helping craft differentials and plans while encouraging thoroughness.

if you are employed. Then, simply obtain patient consent, record the encounter using the AI scribe app on your smartphone (audio typically isn't stored, for HIPAA compliance reasons), and voila — a SOAP note appears in seconds, often 90% complete with billing codes suggested. If you haven't tried using an AI scribe yet, you should. Most vendors offer free trials on their websites, where you can use your voice to give a complicated patient history and see how the tool summarizes the history of present illness.

Studies have shown that ambient AI

scribes have reduced documentation time, including after-hours charting,[4] with a 21% drop in burnout rates at large systems such as Mass General Brigham.[5] In my clinic, trialing Dax during clinic meant more eye contact and richer histories, because patients opened up more when I wasn't typing furiously.

Studies have shown that ambient AI scribes have reduced documentation time, including after-hours charting, with a 21% drop in burnout rates.

Of course, you will need to verify and edit AI-produced notes for accuracy, especially in multi-speaker or complex cases. I find that social histories often need more context, which I add manually. AI-produced social histories tend to leave out family, travel, pet, and hobby updates, which I value greatly for continuity.

Tip: Start using an AI scribe with simple acute visits to build your comfort, and then scale. This isn't magic, but it's close, and reclaiming time at home is priceless.

4. ADMINISTRATIVE SUPPORT

Case: A patient's insurer denies coverage for a necessary mobility aid, and you need to write a compelling prior authorization appeal without reinventing the wheel.

Administrative tasks are the bane of primary care, consuming hours on forms, letters, and faxes. (Side note: Why do we still fax in 2025?) AI drafting tools lighten the load by generating templates you can easily tweak. One analysis estimated that AI could eventually automate 30% of family physicians' tasks,[6] potentially enhancing patient access.

Doximity GPT excels here, with HIPAA-compliant prompts for appeals, disability notes, or patient instructions — and, yes, you fax directly from the app. To address the case above involving a prior authorization appeal, you would simply input key clinical details (anonymized if needed), and the tool would craft a criteria-citing letter in seconds, saving 15-20 minutes per task. While AI won't argue with insurers' decisions (yet), it does help us communicate a strong stance with minimal mental effort.

General LLMs such as ChatGPT, Gemini, or Grok can handle generic drafts, but you should avoid inputting a patient's protected health information into these general tools. I've used them for school excuse notes, referral letters, requests for work, patient education, and more, multiplying my time savings across these examples.

Tip: Customize the tone of AI outputs for your intended audience by providing prompts like "keep it empathetic and professional." This can produce a higher quality response.

5. LEARNING SUPPORT

Case: You are prepping a presentation on long COVID while juggling clinic duties, and you need efficient literature synthesis without endless PubMed searching.

Staying current on the medical literature amid information overload is a perpetual challenge, but AI tools such as Elicit act as a research assistant. This resource searches millions of academic papers and clinical trials, with new data sources being added continuously. Based on your query (e.g., "What are the signs, symptoms, and evidence-based treatment options for long COVID?"), these tools can query studies, summarize findings, and extract relevant data. In the above use case, Elicit could help you summarize key papers on post-viral syndromes in hours, not days. It's free for the basic version, with fees for upgrades. Here again, LLMs such as ChatGPT, Gemini, or Grok can also be helpful for research and analysis, but these general tools gather information from diverse sources and have a higher risk of generating misinformation.

Tip: Even if you aren't doing research for presentation purposes, these AI tools can support personal learning and make it more evidence based. Start with the free

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

version and begin experimenting; you can always upgrade later to access more features if needed.

ALL THAT IS GOLD DOES NOT GLITTER

J.R.R. Tolkien wrote in *The Fellowship of the Ring*, "All that is gold does not glitter." In other words, while AI may be glittering brightly right now, the old-fashioned relationships we have with our patients and their families are still golden. Any AI tools we adopt should support us in caring for the people who need us.

In family medicine, where time is our scarcest resource, AI tools can help us reclaim our time without compromising care. In my dual role as clinician and educator, I've seen AI enhance decisions, cut burnout, and enrich teaching. Patients get evidence-based care faster, residents learn the "why," and physicians reclaim their evenings. The key is to start small: Identify your pain point, pick one tool, pilot it, and assess its impact on your workflows and patients.

AI is no panacea, but thoughtfully integrated, it can amplify our art. FPM

1. Hanna K, Chartash D, Liaw W, et al. Family medicine must prepare for artificial intelligence. *J Am Board Fam Med*. 2024;37(4):520-524.

2. Hurt RT, Stephenson CR, Gilman EA, et al. The use of an artificial intelligence platform OpenEvidence to augment clinical decision-making for primary care physicians. *J Prim Care Community Health*. 2025;16:21501319251332215.

3. Chaudry S, Lee D, Wright S. 20 tips for using an AI virtual scribe to document office visits. *Fam Pract Manag*. 2025;32(2):5-8.

4. Tierney AA, Gayre G, Hoberman B, et al. Ambient artificial intelligence scribes: learnings after one year and over 2.5 million uses. *NEJM Catal Innov Care Deliv*. 2025;6(5).

5. You JG, Dbouk RH, Landman A, et al. Ambient documentation technology in clinician experience of documentation burden and burnout. *JAMA Netw Open*. 2025;8(8):e2528056.

6. Muro M, Maxim R, Whiton J. *Automation and Artificial Intelligence: How Machines Are Affecting People and Places*. The Brookings Institution. Jan. 24, 2019. Accessed Sept. 2, 2025. https://www.brookings.edu/research/automation-and-artificial-intelligence-how-machines-affect-people-and-places

Curated. Trusted. Ready.

Discover resources designed to help you do your best work.

Explore articles focused on:
- Clinical resources
- Managing Your Practice
- Managing Your Career

Dive In:

Sponsored Educational Resources

HEALTH CARE AFFORDABILITY, SELECT

1. Evaluate health care cost drivers, including statutory, regulatory and administrative burdens, and the impact of fraud, waste, and abuse.

2. Study potential improvements to the delivery system and emerging financing models that reduce the cost of health care.

3. Evaluate the impact insurance design, cost sharing, market structure, and payment policies have on consumers and employers. Consider opportunities to encourage flexibility and innovation in plan design to improve affordability while maintaining access to quality care.

4. Identify options that eliminate barriers for small and midsize employers to offer health care coverage.

5. Examine the impact of consolidation on patient choice, market competition, and price and value in health care services.

6. Review the level of consumer transparency in health care markets to ensure consumers have access to clear, accurate, and actionable information on prices, benefits, and out-of-pocket costs. Recommend ways to improve consumer engagement and encourage opportunities to evaluate the cost and quality of health care.

7. Review the implementation of prior legislation and other legislative efforts to reduce the price of health care and make recommendations to support and improve their effectiveness.